STUDY OF MEDICAID REIMBURSEMENT RATES FOR MENTAL HEALTH SERVICES IN VIRGINIA

Virginia Department of Medical Assistance Services

November 19, 2007

Table of Contents

EXECUTIVE SUMMARY

In a 2006 report by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC) recommended that the Department of Medical Assistance Services (DMAS) conduct a comprehensive rate study to assess whether behavioral health service rates need to be increased. After meeting with members of the mental health (MH) community, DMAS agreed to form a workgroup with representatives from DMHMRSAS, CSBs and private providers to study mental health and substance abuse rates.

DMAS reimburses four main categories of MH services: 1) community MH services, 2) inpatient services (general acute hospitals, freestanding psychiatric hospitals, state MH facilities, and residential treatment facilities (Level C)), 3) professional psychiatric services, and 4) treatment foster care case management (TFC-CM). Total reimbursement for MH services in state fiscal year (SFY) 2006 was $418.9 million including both fee-for-service (FFS) and Managed Care Organization (MCO) payments.

Except for MH case management, rates for community mental health (CMH) rehabilitation services were set in 1990, 1991, or 1997 and have not been increased. Rates for CMH residential services were established in 2004 and have not been increased. Rates for similar substance abuse services approved in SFY 2008 were based on the existing CMH rates. Using the Medicare Economic Index (MEI), adjusting rates for inflation since 1990 would result in an increase of 53.3 percent over actual expenditures for SFY 2007.

Reimbursement for inpatient services is either tied to costs or a percentage of costs and is increased annually by inflation or cost increases. Effective July 1, 2007, reimbursement for inpatient psychiatric services for general acute hospitals was increased from 78 percent of operating costs to 84 percent.

Rates for professional psychiatric services are updated annually as part of the physician fee schedule to reflect changes in relative values used by Medicare. However, overall physician expenditures have been kept budget neutral relative to expenditures in 1994 unless an increase is authorized in the budget. Effective July 1, 2007, rates for psychiatric services were increased 5 percent. Rates for psychiatric services currently are 80 percent of Medicare rates.

In March 2007, DMAS refined the reimbursement methodology for TFC-CM as directed by the Deficit Reduction Act (DRA) of 2005. The DRA limits the services that can be reimbursed by Medicaid to case management services only. Reimbursement for TFC-CM cannot include treatment.

The workgroup considered the priority areas for rate increases to be CMH services (except case management and community residential) and professional psychiatric services. These services have received little or no increase in rates in 10 to 15 years. The workgroup noted that ideally inpatient services should represent approximately 20 percent of total MH expenditures, but it represents almost 40 percent of Virginia Medicaid expenditures. The workgroup also noted that professional psychiatric services represented the least utilized service when presumably it should

be furnished along with inpatient and community mental health services. The workgroup indicated that rates were a significant factor in the underutilization of professional psychiatric services.

The workgroup made specific recommendations related to the services targeted for rate increases. The workgroup recommended that the rates for CMH services established in 1990 or 1991 should received a 10-percent increase. CMH services established in 1997 should receive a 5-percent increase. Professional psychiatric services in support of the community-based approach were recommended to receive a 10-percent increase. These recommendations would cost $26.4 million in SFY 2009 ($13.0 million GF). These recommendations were made by the workgroup to DMAS, and reflect the consensus of the members of the work group.

BACKGROUND

In the 2006 DMHMRSAS annual report addressing Item 330-F of the 2004 Appropriation Act, the CFBHPPC outlined several issues affecting access to and delivery of MH services. The report specifically recommended that DMAS conduct a comprehensive rate study of outpatient psychiatry and primary care providers (PCPs) providing behavioral health services, acute inpatient hospitalization, day treatment, and intensive in-home family services. DMAS formed a workgroup with representatives from DMHMRSAS, CSBs and private providers to study mental health rates. Workgroup members are listed in Appendix A.

The four main categories of MH services covered by the Medicaid program are 1) community MH and substance abuse services, 2) inpatient services, 3) professional psychiatric services, and 4) treatment foster care case management (TFC-CM).

Community mental health (CMH) services are provided by both public and private providers. Various mental health service providers may contribute to the development of the Individualized Service Plan (ISP) based on a current assessment and evaluation of the recipient's support needs. Providers of CMH services must meet the criteria designated for each service and include licensed mental health professionals (LMHPs), qualified mental health professionals (QMHPs), paraprofessionals, and qualified substance abuse professionals.

Inpatient MH services include services provided in inpatient hospital and residential settings. In 2006, Medicaid reimbursed 42 private acute hospitals, 7 freestanding psychiatric hospitals, 10 state MH facilities, and 22 residential treatment facilities (RTF) (Level C) for inpatient MH services. Services in RTFs (Level C) are considered inpatient because services include room and board, but are lower level than hospital services. Some of these facilities are considered Institutions of Mental Disease (IMDs) and the reimbursement and coverage are subject to specific federal guidelines.

Professional psychiatric services, such as therapy and psychological testing, are delivered by physicians and other practitioners including licensed social workers, clinical psychologists, and professional counselors in both outpatient and inpatient settings. Professional psychiatric services are also furnished by MH clinics.

Children under age 21 in Treatment Foster Care (TFC) who are Seriously Emotionally Disturbed (SED) or children with behavioral disorders, who, in the absence of such programs, would be at risk for placement into more restrictive residential settings, are eligible for Treatment Foster Care - Case Management (TFC-CM). Case managers or caseworkers assigned to these children may be reimbursed for developing treatment planning, monitoring the treatment plan, and linking the child to other community resources needed based on the specific requirements of the child.

Prior to SFY 2008, DMAS did not cover services for substance abuse services, except for limited benefits for pregnant women. Beginning in SFY 2008, the General Assembly (GA) authorized additional community rehabilitation and case management services for substance abuse, similar

to the CMH rehabilitation services, and professional psychiatric services for recipients with only a substance abuse diagnosis.

REIMBURSEMENT METHODOLOGIES

The Medicaid reimbursement methodology and rates vary for each of the MH services.

Community Mental Health (CMH) Services

For the purposes of this report, the services in Table 1 will be discussed as CMH services:

Table 1 – Community Mental Health Services

Community MH Services	
Community MH Rehabilitation Services	**Community MH Residential Services**
Rates Established in 1990-1991	**Rates Established in 2004**
Intensive In-Home (Children)	Community-Based Residential Services for Children and Adolescents under 21 (Level A)
Crisis Intervention (Children/Adults)	Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B)
Day Treatment (Children/Adults)	**Mental Health Case Management**
Day Treatment/Partial Hospitalization (Adults)	**Most Recent Rate Increase in 2004**
Psychosocial Rehabilitation (Adults)	**New Community Substance Abuse Services Established in 2007**
Rates Established in 1997	**Rates Comparable to 1990-1991 CMH Rates**
Intensive Community Treatment (Adults)	Substance Abuse Case Management
Crisis Stabilization (Children/Adults)	Substance Abuse Crisis Intervention
Mental Health Support (Adults)	Substance Abuse Intensive Outpatient
Substance Abuse Residential Treatment/Pregnant Women (Adults)	Substance Abuse Day Treatment
Substance Abuse Day Treatment for Pregnant Women (Adults)	Substance Abuse Opioid Treatment

All of these services are administered through the FFS program and are carved out of the managed care program. The services are reimbursed based on the DMAS fee schedule and the various unit definitions in the DMAS provider manual. Some of the services have differential rates for urban and rural providers. The community rehabilitation services were implemented either in 1990, 1991, or 1997. The community residential services were implemented in 2004. Unlike rates for residential treatment facilities, rates for community residential services do not include reimbursement for room and board. None of the rates, with the exception of MH case management, have been adjusted since they were implemented. The units and rates for individual services are listed in Appendix B.

If CMH services were adjusted for inflation using the Virginia hospital index since 1990 (base year for most CMH rates), a one hundred percent increase over the actual expenditures for SFY 2007 would result. Using the consumer price index, adjusting rates for inflation since 1990 would result in a 71-percent increase over actual expenditures for SFY 2007. However,

considering the type of services provided in the community setting, the most appropriate index to apply to the CMH services is the Medicare Economic Index (MEI). The MEI measures changes in physician compensation, practice expenses, and other related expenses. Adjusting the rates by the MEI since 1990 for the services established in 1990 to 1991 would increase expenditures by 53.3 percent of the SFY 2007 expenditure level. Adjusting the rates by the MEI for the services established in 1997 would increase expenditures by 30.0 percent of the SFY 2007 expenditure level.

An evaluation of the rates for the CMH services in relation to other payers of these services was inconclusive. CSA uses a rate structure that is similar to the DMAS rate structure; however, the CSA billing requirements and administrative burden are different from the DMAS requirements. Also, the CSA client population may be significantly different than the Medicaid population and the day treatment rates paid by CSA providers may be more advantageous to the provider for several reasons. In addition, the CSA program may reimburse for services not covered by Medicaid as part of the CSA day treatment rate.

An examination of Community Services Board (CSB) cost data submitted to DMHMRSAS appeared to suggest that Medicaid reimbursement was equal to or greater than the CSB cost per unit. CSB unit cost is calculated by dividing total cost by total service hours, even though all units of service are not reimbursed. Medicaid reimbursement may subsidize reimbursement in total for services provided by the CSBs. Medicaid is not the only payer for services provided by the CSBs; therefore, the cost per unit analysis is not a reliable predictor of Medicaid rate adequacy.

Community Substance Abuse Rate Issues

On a limited basis, DMAS implemented community substance abuse (SA) services for pregnant and postpartum women for both day treatment and residential treatment in 1997. Payment for expanded community SA services was implemented on July 1, 2007. The new community SA rates were based on rates for existing CMH rehabilitation services originally set in the early 1990s. The Centers for Medicare and Medicaid Services (CMS), the federal Medicaid oversight agency, required DMAS to use 15-minute time increments and different rates for different levels of qualifications for the new community SA services. Providers of the new community SA services have voiced concern regarding the level of reimbursement for the new community SA services. Providers have stated that they will not render the services, due to the low rates.

Inpatient Services

Inpatient services consist of services performed in 1) general acute hospitals, 2) freestanding psychiatric hospitals, 3) state MH facilities, and 4) residential treatment facilities (Level C). Medicaid-enrolled inpatient facilities provide acute care psychiatric services that are ordinarily furnished to an individual in an inpatient hospital setting for the care and treatment of MH conditions or diseases. With the exception of state mental hospitals, professional psychiatric services furnished in an inpatient setting are reimbursed separately from facility service.

General Acute Hospitals

General acute hospitals are paid per diem rates that are rebased at least every three years, most recently for SFY 2008. The base year for the SFY 2008 rebasing was SFY 2005 cost reports. The statewide per diem rate is adjusted by differences in wages by Metropolitan Statistical Area.

Per diem rates are inflated annually between each rebasing. Capital costs are reimbursed at 80 percent retrospectively. During the 2007 GA Session, the adjustment factor for hospitals that provide acute psychiatric services was raised from 78 percent of operating costs to 84 percent of operating costs. All other acute inpatient rates are based on 78 percent of operating costs. Medallion II also covers inpatient services in general acute care hospitals, and MCOs generally reimburse at rates that are comparable to Medicaid rates.

State Mental Health Facilities

Psychiatric services provided by state mental health facilities are reimbursed an interim per diem based on prior year costs inflated by one year. Reimbursement is settled to cost submitted by the state mental health facilities.

Freestanding Psychiatric Hospitals

The rates for freestanding psychiatric hospitals are per diem rates based on 1998 Medicare cost reports. The per diem is inflated annually and includes reimbursement for capital costs. During the 2007 GA Session, effective for SFY 2008, freestanding psychiatric hospitals will no longer be rebased; the rates will continue to be based on the 1998 Medicare cost reports and inflated annually. Analysis of the facilities' costs indicates that the current reimbursement to freestanding psychiatric hospitals slightly exceeds the costs incurred by the facilities.

Residential Treatment Facilities (Level C)

RTFs are paid a per diem rate that is the lower of the annual negotiated rate for Comprehensive Services Act (CSA) children or the Medicaid ceiling. Non-CSA per diem rates are established by determining allowable costs subject to the Medicaid ceiling. The per diem rates and Medicaid ceiling are inflated annually. The original rates and ceilings were calculated on January 1, 2000 for private residential treatment facilities; currently no timetable for rebasing exists.

IMD Reimbursement Issue

All of the inpatient facilities, except general acute care hospitals, are considered Institutions of Mental Disease (IMD). An Institution of Mental Disease (IMD) is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services". Under federal regulations, an IMD may only provide services for Medicaid recipients who are either younger than the age 21 or older than age 64.

The Office of the Inspector General (OIG) has issued an audit report of Virginia IMDs in which they recommend a disallowance of federal funds for payments made on behalf of IMD recipients under age 21 for services other than the inclusive per diem rate to the IMD. According to the OIG, the IMD rate must be all inclusive covering all services furnished. These services identified by the OIG as being paid outside the rate include physician services (for which Virginia's State Plan specifically requires separate payment), as well as other services such as pharmacy. OIG recommendations would affect reimbursement to freestanding psychiatric hospitals and RTF (Level C). DMAS currently includes all costs in reimbursement to state mental facilities. The audit finding has not been resolved.

Professional Psychiatric Services

Professional psychiatric services are those services in CPT code ranges 90801-90899 and 96100-96103 and include:

- Diagnostic Testing
- Individual Psychotherapy
- Family Psychotherapy
- Group Psychotherapy
- Medication Management
- Psychiatric evaluation of hospital records
- Psychological Testing

Physicians and other practitioners (e.g., licensed social workers and counselors) may provide psychiatric services. MH clinics may also provide comparable services. These services are provided to recipients in either outpatient or inpatient settings.

The reimbursement methodology for professional psychiatric services in the FFS program is based on the Resource Based Relative Value Scale (RBRVS) used by Medicare for physician services. Unlike Medicare, DMAS does not apply a geographic adjustment or a site of service differential. Licensed clinical psychologists receive 90 percent of the psychiatrist (M.D.) rate. Licensed clinical social workers, professional counselors, clinical nurse specialists, psychiatric nurse practitioners, and marriage and family therapists receive 75 percent of the psychologist rate (67.5 percent of the psychiatrist (M.D.) rate). The fees for professional services are updated annually on July 1 based on CMS' annual update (effective each January).

Professional fees are not adjusted for inflation. Expenditures are kept budget neutral by applying a budget neutrality factor (BNF). Following recent increases to different categories of physician services, DMAS has separate BNFs for each category. Psychiatric services are included in the "all other" category of physician services, along with surgery, radiology, pathology, and other medical procedure codes. A five-percent increase to "all other" fees was effective July 1, 2007, the first increase for this category since 1994. Psychiatric professional expenditures are currently approximately 80 percent of Medicare; expenditures for other categories of physician services are between 70 percent and 99 percent of Medicare. Medallion II also covers professional psychiatric services and MCOs pay at least what Medicaid pays.

Treatment Foster Care Case Management

Recipients identified as needing TFC-CM are assigned case managers or caseworkers who provide treatment planning, monitor the treatment plan, and link the child to community resources as necessary to address the child's special identified needs. Services are delivered primarily by treatment foster parents who are trained, supervised, and supported by professional child-placing agency staff. TFC-CM providers are reimbursed a monthly rate negotiated by the local Community Policy and Management Team (CPMT) in the locality, which is responsible for the child's care. The daily rate is based on CM intensity, subject to an upper limit set by DMAS.

The Deficit Reduction Act (DRA) of 2005 requires DMAS to limit Medicaid reimbursement for treatment foster care case management services. Although case management services are still permitted by the DRA, the definition has been narrowed. Section 1396n(g)(2) of the DRA

defines case management as “services which will assist Medicaid eligible individuals in gaining access to needed medical, social, educational, and other services.” Case management may only include reimbursement for coordination and linking the client to medical, educational, social, or other services and not the direct provision of such services. Effective March 1, 2007, DMAS required monthly billing for a maximum reimbursement rate of $326.50 per month for the TFC-CM provider. This maximum ceiling rate is not rebased or adjusted for inflation.

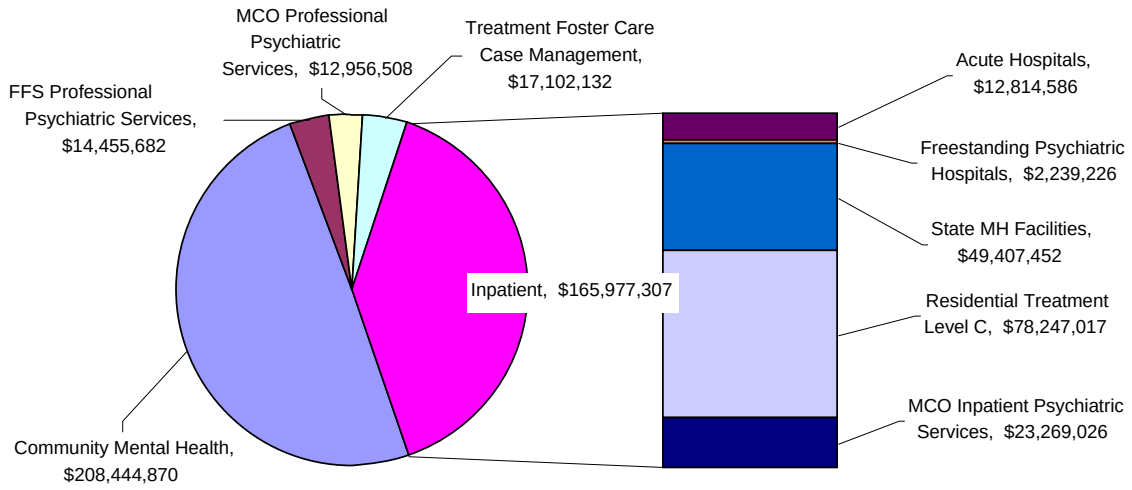
A TFC Rate Setting Workgroup is developing a statewide rate and addressing federal and state changes to payment policies as directed by the GA in 2007. This workgroup consists of representative from the Office of Comprehensive Services for At-Risk Youth and Families, the Department of Social Services, DMAS, and representatives from the TFC provider associations. The TFC Rate Setting Workgroup expects shift in reimbursement for TFC-CM from Medicaid to Title IV-E or CSA as a result of the coverage changes mandated by the DRA.

EXPENDITURES AND UTILIZATION

In SFY 2006, DMAS spent $418,936,499 on mental health services, including $36,228,534 in managed care expenditures for inpatient and professional psychiatric services. (See Figure 1) CMH services comprise almost half of the MH expenditures for the Medicaid program or $208,444,870. The majority of the expenditures were for rehabilitation services, $135,461,658, with an additional $66,401,151 for case management and $6,582,061 for community residential services.

The expenditures for inpatient services also occupy a substantial portion of the MH services, approximately 40 percent of the total. In SFY 2006, DMAS FFS reimbursed 42 acute hospitals $12,814,586 for 20,882 days. MCOs spent an additional $23,269,026. DMAS reimbursed 10 freestanding state mental health facilities a total of $49,407,452 for 111,640 days in SFY 2006. In SFY 2006, DMAS paid the seven private freestanding psychiatric hospitals $2,239,226, with the majority of these expenditures paid for services provided to recipients under age 21. Expenditures for the approximately 22 residential treatment facilities (RTFs) total $78,247,017 in SFY 2006.

Figure 1 - Mental Health Expenditures
MCO and FFS, SFY 2006 (Total)

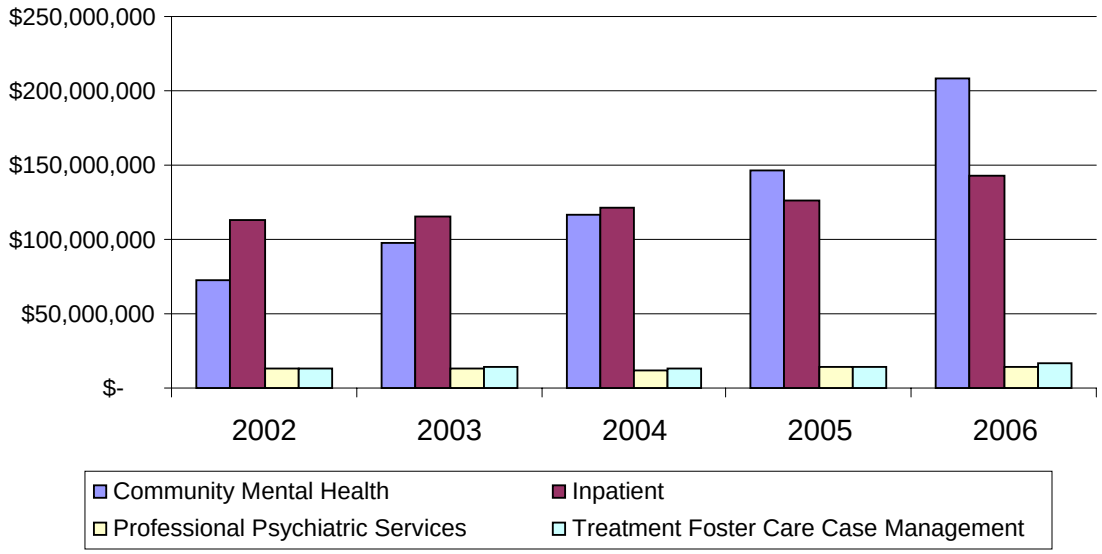


Total Mental Health Payments in SFY 2006: $418,936,499

Payments for professional psychiatric and TFC-CM services are significantly lower than payments for CMH and inpatient services. Professional psychiatric services in the FFS program totaled $14,455,682 in SFY 2006; these same services provided by the MCO program totaled $12,956,508. The professional psychiatric expenditures include unbundled professional psychiatric services associated with inpatient psychiatric services provided in inpatient and residential settings. In SFY 2006, DMAS reimbursed $17,102,132 for TFC-CM.

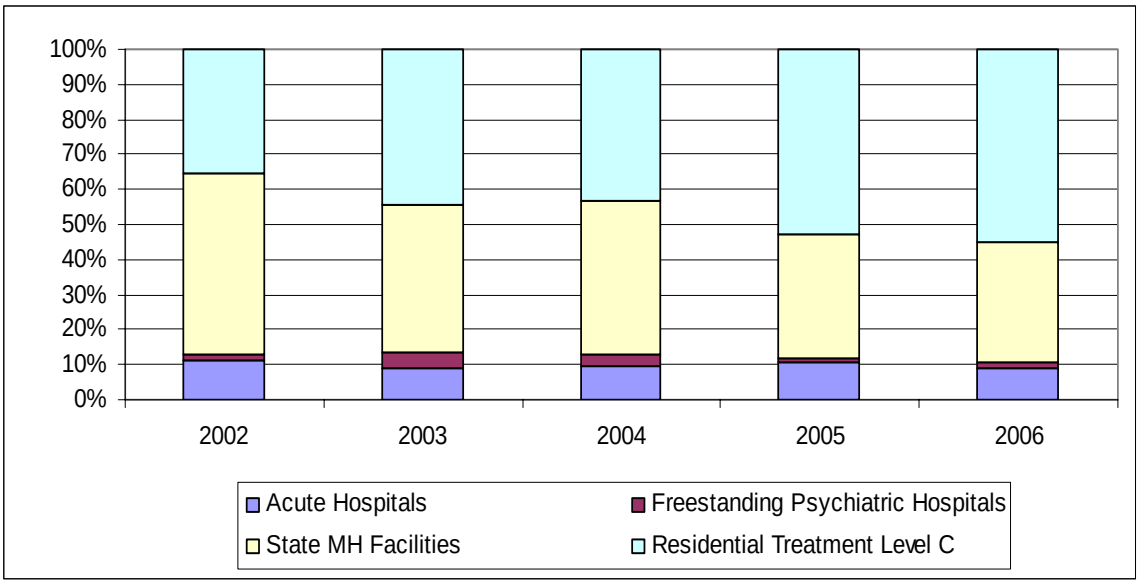
Figure 2 shows expenditure increases between 2002 and 2006. In addition to being the largest expenditure category of MH services, CMH services appear to the fastest growing segment of the MH services. CMH expenditures more than tripled, due primarily to increased utilization (more recipients receiving services and more services per recipient). Except for case management, there has not been any rate increases for CMH services.

Figure 2 - Mental Health Expenditures (FFS)



Inpatient expenditures have increased modestly, primarily due to annual rate increases for inflation. Figure 3 shows that about 15 percent of total expenditures for inpatient services have shifted from state mental health facilities to residential treatment facilities between 2002 and 2006, while the share of total expenditures for services in acute and freestanding psychiatric hospitals remained relatively stable. Expenditures for psychiatric services and TFC-CM have been flat. In regards to professional psychiatric services, there have been no rate or utilization increases.

Figure 3- Inpatient Mental Health Expenditures (FFS)



In SFY 2006, the expenditures for CMH rehab services were 58.7 percent of all expenditures for CMH services. The CMH services with rates established in 1990 or 1991 comprised 45.1 percent of CMH total expenditures in contrast to the expenditures for services with rates established in 1997, which were only 13.6 percent of CMH expenditures. (See Table 2). Table 2 demonstrates that the services for rates set in 1990 or 1991 were the bulk of CMH rehab expenditures (76.8 percent). Case management services occupy the second largest portion of the CMH services, 38.3 percent.

Table 2 – Distribution of Community Mental Health Expenditures by Service SFY 2006

Category	Description	Percent of Total CMH
Community Mental Health Rehabilitation		58.7%
Rates Established in 1990-1991		45.1%
	Crisis Intervention	0.9%
	Intensive In-Home Services for Children and Adolescents	22.5%
	Psychosocial Rehabilitation	9.3%
	Therapeutic Day Treatment for Children and Adolescents	12.3%
Rates Established in 1997		13.6%
	Crisis Stabilization	0.9%
	Intensive Community Treatment	2.8%
	Mental Health Support	9.9%
CMH Residential		2.6%
Community Substance Abuse for Pregnant Women		0.3%
Mental Health Case Management		38.3%

Table 3 illustrates the growth rates in CMH services by subcategory and component of growth. Overall, the number of recipients who received CMH services more than doubled and CMH expenditures per recipient increased 68 percent between SFY 2002 and SFY 2006. The growth in recipients was greater for MH case management services than for CMH rehabilitation services. Expenditures per recipient between 2002 and 2006 grew at about the same rate for both CMH rehabilitation and MH case management. The 52.5 percent growth in expenditures per recipient for MH case management services is explained by the 57 percent rate increase from SFY 2002 to SFY 2006. The case management rate was increased as part of a revenue maximization initiative to reduce the general fund (GF) expenditures paid to CSBs and obtain the federal match for these services paid through the Medicaid program. The growth in expenditures per recipient for CMH rehabilitation reflects an increase in services per recipient since there have been no rate increases. Expenditures for CMH residential and community SA services are not a significant factor in the total growth.

Table 3 – Expenditures, Recipient and Expenditures Per Recipient By Subcategories of CMH Services, SFY 2002-2006

Category	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	1-Year Growth	4-Year Growth
Total							
Expenditures	$74,271,498	$97,276,146	$132,215,007	$186,840,576	$251,855,146	34.8%	239.1%
Recipients	24,586	27,181	38,236	44,535	49,623	11.4%	101.8%
Expenditures Per Recipient	$3,021	$3,579	$3,458	$4,195	$5,075	21.0%	68.0%
CMH Rehab							
Expenditures	$49,127,607	$61,658,396	$79,261,894	$109,237,169	$147,867,717	35.4%	201.0%
Recipients	17,592	19,365	28,484	27,148	33,689	24.1%	91.5%
Expenditures Per Recipient	$2,793	$3,184	$2,783	$4,024	$4,389	9.1%	57.2%
MH Case Management*							
Expenditures	$24,812,722	$34,832,930	$52,122,017	$73,305,984	$96,491,296	31.6%	288.9%
Recipients	17,066	19,121	43,923	37,680	43,528	15.5%	155.1%
Expenditures Per Recipient	$1,454	$1,822	$1,187	$1,945	$2,217	13.9%	52.5%
CMH Residential							
Expenditures				$3,417,348	$6,651,915	94.7%	
Recipients				157	288	83.4%	
Expenditures Per Recipient				$21,767	$23,097	6.1%	
Community SA for Pregnant Women							
Expenditures	$331,169	$784,820	$831,096	$880,074	$844,218	-4.1%	154.9%
Recipients	61	80	92	100	102	2.0%	67.2%
Expenditures Per Recipient	$5,429	$9,810	$9,034	$8,801	$8,277	-6.0%	52.5%

*Data may reflect both MH and MR case management prior to SFY 2005

Note: The sum of recipients by subcategory exceeds total recipients because the same recipients may be included in more than one subcategory.

The workgroup considered the growth in recipients receiving CMH services and the higher intensity of services provided (reflected in the increase in expenditures per person) as a positive development, filling unmet needs for CMH services. However, this growth somewhat undercuts the argument for a rate increase, if access to services has grown this dramatically without a rate increase. One workgroup member noted that even though services have increased to meet the unmet need, there is a risk that the quality of services furnished will decline due to the need to expand case load sizes to compensate for the low rates.

The analysis of the CMH and professional psychiatric therapy data focused on the differences in adult and child populations. Table 4 shows expenditures for intensive in-home services provided to children in SFY 2006 were 38.4 percent of all CMH rehab services. The expenditures for CMH rehab services established in the 1990s were mostly services provided to children, 60.4 percent compared to 39.6 percent for adults. Children also received most of the services paid with rates that were set in 1990 or 1991, 59.6 percent of total CMH rehab expenditures compared to 17.1 percent of total CHM rehab expenditures for adults. Any rate increase to CMH rehab and SA services will substantially impact expenditures for children and, ultimately, the extent of services provided to children. For the adult population, the largest portion of CMH rehab expenditures fell into mental health support (16.2 percent) and psychosocial rehabilitation services (15.7 percent).

Table 4 – Distribution of CMH Rehabilitation Expenditures by Service and Age, SFY 2006

Percent of All CMH Rehab Services		Children	Adults	Children and Adults
Services Established in 1990-1991		59.6%	17.1%	76.8%
	Crisis Intervention	0.6%	1.0%	1.6%
	Intensive In-Home Services for Children and Adolescents	**38.4%**	0.0%	38.4%
	Psychosocial Rehabilitation	0.2%	15.7%	15.9%
	Therapeutic Day Treatment for Children and Adolescents	20.5%	0.4%	21.0%
Services Established in 1997		0.8%	**22.5%**	23.2%
	Crisis Stabilization	0.1%	1.5%	1.5%
	Intensive Community Treatment	0.0%	4.8%	4.8%
	Mental Health Support	0.7%	**16.2%**	16.8%
	Substance Abuse for Pregnant Women	0.0%	0.6%	1.2%

The analysis of the CMH and professional psychiatric services data also matched the number of recipients in both the adult and child populations receiving CMH services to the number of recipients receiving professional psychiatric services, including services covered by MCOs. Overall, at least 54.6 percent of all children who received CMH services also received at least one professional psychiatric service. Overall, at least 40.3 percent of all adults who received CMH services also received at least one professional psychiatric service.[1]

The workgroup noted that most recipients receiving CMH services, including those receiving only case management, should also receive a least some professional psychiatric services. The fact that a significant percentage of recipients who received CMH services did not receive professional psychiatric services probably reflects the lack of available services. Case managers and CMH providers, however, may also have to increase their efforts to link CMH recipients to professional psychiatric services.

[1] The analysis includes MCO encounters for professional psychiatric services, which may be underreported.

In aggregate, physicians and clinics supply professional psychiatric therapy services equally in inpatient (47.5 percent) and outpatient settings (52.5 percent), but most psychiatric services for children are inpatient, presumably in RTFs, while the overwhelming majority of psychiatric services for adults are outpatient (See Table 5).

Table 5 – Professional Psychiatric Claims by Setting, SFY 2006 (FFS)

	Inpatient Setting	Outpatient Setting	All
Adults	**10.2%**	**89.8%**	**100%**
Children	**56.4%**	**43.6%**	**100%**
Total	**47.5%**	**52.5%**	**100%**

Licensed clinical social workers (LCSW) performed most professional psychiatric services (32.8 percent). Physician services represent 20.6 percent of therapies. Licensed professional counselors (LPC) serviced 18.7 percent of all recipients needing psychiatric therapies. (See Table 6).

Table 6 – Professional and Clinic Claims by Provider Type, SFY 2006 (FFS)

FFS Professional and Clinic Claims by Provider Type	% of Total
Licensed Clinical Social Worker	32.8%
Physician	20.6%
Mental Health Mental Retardation Clinic	14.4%
Licensed Professional Counselor	18.7%
Clinical Psychologist	9.0%
Clinical Nurse Specialist - Psychiatric only	3.2%
Other	1.3%

In SFY 2006, approximately 24% of professional psychiatric services were for medication management, with no other professional psychiatric service billed. Sixteen percent of children and 34.5 percent of adults received medication management services only.

The higher inpatient utilization of professional therapy services for children among LCSWs and LPCs may reflect the shortage of the child psychiatrists or unwillingness of physicians to provide services. According to 2000 and 2001 combined survey data provided by the American Academy of Child & Adolescent Psychiatry, the median starting income for child and adolescent psychiatrists was $141,600, compared to $109,100 for adult psychiatrists. In 2007, more recent data from salary.com indicates that the gap in the salary may be declining nationally. Although the gap in child and adult psychiatrists was reduced over time, providers reported difficulty recruiting child psychiatrists, as a result of the higher salary demands compared to the lower level of reimbursement for professional psychiatric services.

A recent JLARC study on psychiatric services in Virginia noted that Medicare and other insurers pay higher rates than Medicaid for professional psychiatric services. DMAS has calculated that Medicaid professional psychiatric rates are approximately 80 percent of Medicare rates.

However, commercial insurers reportedly do not pay significantly more than Medicare for psychiatric services furnished by psychiatrists, whereas in general, commercial insurers pay 30 to 40 percent more than Medicare to other physicians.

The relatively low rates paid by commercial insurers to psychiatrists services (compared to other physicians) probably contribute to the access problem to these services for all persons, including Medicaid recipients. To some extent, psychiatrists cannot offset the low rates paid by Medicaid with higher rates paid by commercial payers to the degree that other physicians can. A rate increase for psychiatric services may improve access to psychiatric services for Medicaid recipients, but the relatively low rates paid by commercial insurers could continue to affect access to professional psychiatric services by Medicaid recipients, as they do not effectively cross-subsidize DMAS rates.

COST OF RATE INCREASES

The focus and goals of other reports on MH services and advocates of MH services are treatment options in the community. In order to meet the goals of access to community treatment and reduce the expenses associated with inpatient and residential treatment options, the workgroup concentrated on the adequacy of the rates for CMH services and professional psychiatric services. For illustrative purposes, DMAS calculated the cost of a 5-percent rate increase in SFY 2009 for all CMH services (including SA services) except case management and professional psychiatric services in Table 7. This would cost $15.1 million ($7.5 million GF).

Table 7 – Cost of 5-Percent Rate Increase in SFY 2009 (FFS, MCO)

Category			Total Impact of 5% Rate Increase* (GF and NGF)	Total Impact of 5% Rate Increase* (GF)	Total Impact of 5% Rate Increase** (NGF)
Mental Health and Substance Abuse Grand Total			**$15,132,477**	**$7,466,414**	**$7,666,064**
Community Services Total			$13,254,690	$6,546,576	$6,708,114
Community Mental Health Rehabilitation			$12,316,676	$6,077,621	$6,239,055
	Services Established 1990-1991		$9,482,608	$4,660,587	$4,822,021
	Services Established 1997		$2,834,068	$1,417,034	$1,417,034
Community MH Residential			$474,482	$237,189	$237,293
Community Substance Abuse			$463,532	$231,766	$231,766
	Services Established 1997		$45,510	$22,755	$22,755
	New Substance Abuse Community Services		$418,022	$209,011	$209,011
Professional Services Total			$1,877,787	$919,838	$957,950
Mental Health			$1,729,657	$845,773	$883,885
		FFS	$909,489	$449,752	$459,737
		MCO	$820,168	$396,021	$424,148
Substance Abuse			$148,130	$74,065	$74,065
		FFS	$80,706	$40,353	$40,353
		MCO	$67,424	$33,712	$33,712

*Excludes increase for Mental Health Case Management
**Includes Medicaid Expansion and FAMIS

The workgroup recognized different justifications for rate increases and made specific recommendations to target the rate increases. Among the CMH services, those that were established in 1990 or 1991 merit a higher increase than those established in 1997. While access to CMH rehab services has increased despite the lack of a rate increase, no other Medicaid service has gone for such a long time period without a rate increase. A rate increase for the community residential services seems less compelling, because these rates were established only three years ago. The workgroup recommended a 10-percent increase to rates for CMH services established in 1990 or 1991 and a 5-percent increase to rates for CMH services established in 1997. The workgroup also recommended a 10-percent increase to rates for professional psychiatric services. This increase will require that a separate category of physician services be created for the annual update of physician rates. In total, the workgroup's recommendations would cost $26.4 million in SFY 2009 ($13.0 million GF).

As previously mentioned, the rates originally set in 1990 or 1991 are for services that have the highest utilization among children. An increase to these rates will affect services provided to children more than services provided to adults. The adult population's utilization is split almost equally between the 1990 rates (43.3 percent) and the 1997 rates (56.7 percent).

CONCLUSION

This report examined the rate structures of MH services in response to recommendations from DMHMRSAS and MH community representatives requesting DMAS to evaluate the rate adequacy of Medicaid rates for MH services. The workgroup for this report identified the need to increase rates for CMH and professional psychiatric services in order to promote and support MH services in the community rather than inpatient settings.

As part of the community focus, the workgroup recommends rate increases for services that have not been adjusted or increased in the last 10 to 15 years. Specifically, the workgroup proposes a 10-percent increase for CMH services with rates originally set in 1990 or 1991; a 5-percent increase for CMH services with rates established in 1997; and a 10-percent increase for professional psychiatric services to supplement and support the community-based approach to mental health services. The total funding needed for the proposed rate increases to be effective in SFY 2009 is approximately $26.4 million ($13.0 million GF).

APPENDIX A

Workgroup Members

Name	Agency/Organization
Jim Martinez	Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)
Catherine Hancock	Department of Medical Assistance Services (DMAS)
Brian Meyer	Virginia Treatment Center for Children (VTCC)/Virginia Commonwealth University Health System (VCUHS)/Child and Family Behavioral Health Policy and Planning Committee (CFBHPPC)
John Morgan	Voices for Virginia's Children
Donna Pierce-Baylor	Association for Youth Residential Facility/ Virginia Coalition of Private Provider Associations (VCOPPA)
Beth Rafferty	Richmond Behavioral Health Authority (RBHA)/ Virginia Association of Community Services Boards (VACSB)
Karen Waters	Chesterfield Community Services Board (CCSB)/ Virginia Association of Community Services Boards (VACSB)
Wanda Sadler	Hallmark/ Virginia Coalition of Private Provider Associations VCOPPA
Frank Tetrick III	Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)
Scott Crawford	Department of Medical Assistance Services (DMAS)
Catherine Hancock	Department of Medical Assistance Services (DMAS)
William Lessard	Department of Medical Assistance Services (DMAS)
Carla Russell	Department of Medical Assistance Services (DMAS)

APPENDIX B

Community Mental Heath and Substance Abuse Services, Units, Rates

Code	Modifier	Unit	Description	Differential	1990-1991 Rates	1997 Rates	2004 Rates	2008 Rates
H2012		Hour	Intensive In-Home Services for Children and Adolescents		$ 70.00			$ 70.00
H0035	HA	2 up to 3 hrs 3 up to 5 hrs 5 or more hrs	Therapeutic Day Treatment for Children and Adolescents	Child	$ 38.05			$ 38.05
H0035	HB	2 up to 4 hrs 4 up to 7 hrs 7 or more hrs	Day Treatment/Partial Hospitalization	Non-Child	$ 36.23			$ 36.23
H0036		15 minutes	Crisis Intervention	Urban	$ 30.79			$ 30.79
				Rural	$ 18.61			$ 18.61
H0039		Hour	Intensive Community Treatment	Urban		$ 158.00		$ 153.00
				Rural		$ 144.00		$ 139.00
H2019		Hour	Crisis Stabilization	Urban		$ 89.00		$ 89.00
				Rural		$ 81.00		$ 81.00
H0046		1 up to 3 hrs 3 up to 5 hrs 5-7 hrs	Mental Health Support	Urban		$ 91.00		$ 91.00
				Rural		$ 83.00		$ 83.00
H0018	HD	Day	Substance Abuse Residential Treatment/Pregnant Women	Urban		$ 120.00		$ 120.00
				Rural		$ 108.00		$ 108.00
H0015	HD	Day	Substance Abuse Day Treatment for Pregnant Women	Urban		$ 60.00		$ 60.00
				Rural		$ 54.00		$ 54.00
H2022	HK/HW	Day	Community-Based Residential Services for Children and Adolescents Under 21 (Level A)				$ 119.20	$ 119.20
H2020	HK/HW	Day	Community-Based Residential Services for Children and Adolescents Under 21 (Level B)				$ 158.93	$ 158.93
H2017		2 up to 4 hrs 4 up to 7 hrs 7 or more hrs	Psychosocial Rehabilitation		$ 24.23			$ 24.23
H0023		Month	Mental Health Case Management**		$ 208.25		$ 260.00	$ 326.50
H0006		15 minutes	Substance Abuse Case Management					$ 16.50*
H0050		15 minutes	Substance Abuse Crisis Intervention					$ 25.00*
H2016		15 minutes	Substance Abuse Intensive Outpatient					$ 4.00*
H0047		15 minutes	Substance Abuse Day Treatment					$ 4.00*
H0047		15 minutes	Substance Abuse Opioid Treatment					$ 4.00*

Source: CMH Rehab Services Provider Manual, Ch. IV, page i, revised 7/5/2007
**Rates for masters level professional; where appropriate DMAS pays 75 percent of rate for bachelors level;56.2 percent for less than bachelors level*
***MH Case Management rate increased to $260.00 effective 7/1/2002; $326.50 effective 7/1/2005*